Appendix B: CHIP B

Note: Information in this section pertains only to claims with dates of service prior to 7/1/2006 for children covered under the CHIP-B program. CHIP-B is no longer a valid benefit package for dates of service after 6/30/2006.

B.1 CHIP-B Overview

B.1.1 Overview

The Children's Health Insurance Program (CHIP) is a Title XXI program administered by the State of Idaho, Department of Health and Welfare. Currently there are two types of CHIP programs:

- CHIP-A covers eligible children at the same level of coverage as a traditional Medicaid participant. **Beginning July 2006, children enrolled in CHIP-A will be transitioned to Medicaid Basic or Enhanced Plan Benefits, based on individual health needs. This transition will occur at the participant's annual renewal.**
- CHIP-B is a basic health care program, administered by the State, which pays for primary health care services and provides **limited** medical coverage for qualified children. CHIP-B was created in response to legislation enacted by the 2003 Idaho Legislature. The intent of this legislation is to increase the availability of affordable, basic health care insurance to currently uninsured children. The Idaho Medicaid program implemented the CHIP-B program on July 1, 2004.

A child participant may move between the Idaho Medicaid, CHIP-A, and CHIP-B programs. See **Section 1** for more information on general Medicaid eligibility requirements.

B.1.2 Participant Identification Number

The Department of Health and Welfare uses the Idaho Medicaid identification system to assign an identification number to each participant in the CHIP-B program. This Medicaid identification number (MID) is a seven-digit number that can be used by the participant for the CHIP-B program as well as the Idaho Medicaid program depending on the participant's eligibility for the date of service.

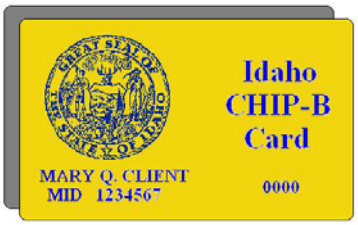
B.1.3 Eligibility

B.1.3.1 Period of Eligibility

Participant eligibility CHIP-B is determined on a month-to-month basis. For example, a participant may be eligible for CHIP-A during June and eligible for CHIP-B during July and August.

Prior to providing services, participant eligibility should be verified through MAVIS, EDS software (PES), EDS-tested vendor software, or HIPAA-compliant point of service devices (POS). Medicaid only reimburses for services rendered while the participant is eligible for benefits. Confirmation eligibility is not available for dates in the future. CHIP-B Identification Card

Sample CHIP-B Card



A plastic identification card is issued at the time a participant becomes eligible for CHIP-B benefits. All CHIP-B participants receive a yellow plastic ID card with the words "Idaho CHIP-B Card" on the front. Possession of an identification card does not guarantee CHIP-B eligibility.

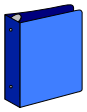
Providers should request the CHIP-B identification card and retain a copy of this documentation for their records.

B.1.3.2 Verifying CHIP-B Eligibility

Verify eligibility each time services are rendered. Eligibility information can be accessed four different ways. They are:

- EDS billing software (PES)
- Medicaid Automated Voice Information Service (MAVIS)
- HIPAA-compliant vendor software (tested with EDS)
- HIPAA-compliant point of sale devices (POS)

For more information



see **Section 1.3.3** for verifying eligibility

see **Section 1.3.4** and the **MAVIS Appendix** for more on MAVIS

Participant eligibility information that is available includes Healthy Connections data, program and certain service limitations, procedure code inquiries, third party recovery (TPR), Medicare coverage information, and lock-in data. To obtain eligibility information, submit two participant identifiers from the following list:

- Medicaid Identification Number (MID)
- Social Security Number (SSN)
- Last name, first name
- Date of birth

B.1.3.3 Eligibility Response

Interpreting Eligibility Response Information

It is important to interpret eligibility information accurately to ensure correct claims payment.

If using EDS billing software (PES) or other HIPAA compliant vendor software the program description returned will indicate **CHIP-B**.

If using Point-of-sale devices, the program description will indicate **CHIP-B**.

If using MAVIS, the dialog spoken is that the participant is enrolled "**with benefits restricted to CHIP-B related services only**", or if using the fax-back feature the program description will indicate **CHIP-B**.

B.1.4 CHIP Contact Information

For general information about CHIP contact:

CHIP-A: Idaho Care Line (800) 926-2588 or TDD (208) 332-7205

CHIP-B: CHIP Unit
150 Shoup Ave Suite # 5
Idaho Falls, ID 83402-3653

(866) 326-2485

B.1.5 Covered Benefits

The **CHIP-A** program is a full-coverage medical program. Participants can receive all services that are included in regular Medicaid coverage. Refer to **Section 3**, Provider Guidelines, for specific service coverage and billing details for individual programs and specialties.

The **CHIP-B** program offers limited medical coverage to qualified applicants. CHIP-B services will be reimbursed at the current Medicaid reimbursement rate and are subject to all current billing requirements, edits, and limitations for services under the regular Medicaid program.

Covered services for CHIP-B include:

- Birthing center services (currently no providers in Idaho)
- Bone, bone marrow, skin and corneal transplant services
- Emergent ambulance/air ambulance services
- Essential Care services (District Health Departments, Indian Health Services Clinics, Rural Health Clinics)
- Federally Qualified Health Center services
- Hearing services (Audiologist and Hearing Aids provided by an Audiologist)
- Hospital services (inpatient and outpatient)
- Inpatient Mental Health services (up to 30 days per year)
- Laboratory services
- Physician, osteopath, and mid-level practitioner services
- Prescription drugs
- Radiology services (includes mobile x-rays)
- Rehabilitative option for rehabilitative mental health services
- Services provided by Mental Health Clinics, Regional Mental Health Clinics, and Diabetes Clinics
- Vision services

B.1.5.1 CHIP-B Non-covered Services

Prior to rendering services, providers must inform participants when services are **not** covered under their medical coverage program. Idaho Medicaid strongly encourages the provider to have the participant sign an informed consent regarding any non-covered services. If the participant chooses to obtain services that are not a covered service, it is the participant's responsibility to pay charges for services that are not covered under the CHIP-B program.

See **Section 1.1.2, Provider Responsibilities,** in the General Provider and Participant information section of this handbook for additional details.

The following is a list of **non-covered** services for CHIP-B participants:

- All Waiver services (Personal Care Services, Nursing Services, DD, TBI and ISSH)
- Case management services (except Healthy Connections primary care case management)
- Chiropractic services
- Dental services
- Dietician services
- Durable medical equipment and supply services
- Home health services
- Hospice services
- Long term care services
- Non-emergent transportation services (Commercial, Individual, Agency and Non-Medical Waiver Transportation)
- Physical therapy services provided by Independent Physical Therapists
- Podiatry services
- Rehabilitative Option for Developmental Disabilities Agencies and School Based services
- Services provided by Diagnostic, PW, and Speech and Hearing Clinics
- Social worker services
- Transplant services (excluding bone, bone marrow, skin and corneal transplants)
- Unit dose pharmacy services

B.2 Lock-In Program

B.2.1 Participant Program Abuse/Lock-In Program

DHW reviews CHIP-B participant utilization to determine if services are being used at a frequency or amount that results in a level that may be harmful or not medically necessary. All the same lock-in guidelines apply for a CHIP-B participant as a traditional Medicaid or CHIP-A participant. See Section 1.3.5 for additional information about the lock-in program.

B.2.1.1 Remittance and Status Reports

The provider's **remittance and status report** has up to three different payouts associated with lock-in case management fees. These payouts are displayed in the **Financial Transactions** section. Each type of payout is identified by a different financial reason code.

- Financial reason code **128** is the lock-in payout for all participants enrolled in a traditional Medicaid program.
- Financial reason code **130** is the lock-in payout for all participants enrolled in the CHIP-A program.
- Financial reason code **131** is the lock-in payout for all participants enrolled in the CHIP-B program.

B.2.1.2 Participant Roster Report

Providers with lock-in participants receive a participant roster that includes CHIP-B participants. The roster is separated into two categories, Medicaid and CHIP-B. The **Medicaid** category includes both traditional Medicaid and CHIP-A participants. The **CHIP-B** category includes only CHIP-B participants.

B.2.1.3 Participant Roster Report Field Descriptions

Report Field	Description
PAGE	Page number for reports.
RUN DATE:	The date and time for reporting run time.
PERIOD:	From date in MM/DD/CCYY format.
THRU:	To date for reports in MM/CCYY format.
PROV ID	Provider ID is a unique number assigned by the State to each provider participating in the Medicaid program.
PROV NAME	Name of Medicaid provider. Last name then first.
NONE	Name of the program in which the participant is enrolled. One possible value is 'Medicaid'. Other values may exist as new programs are added to the system.
MID	Number assigned by the State's EPIC system that uniquely identifies an individual eligible for Medicaid benefits.
PERSON NAME	Last name of the person.
NONE	First name of the person.
TYPE	Code that identifies the type of lock-in segment.
START DATE	From date in MM/DD/CCYY format.
STOP DATE	To date for reports in MM/CCYY format.

B.2.1.4 Participant Roster Report

REKR401 IDAHO MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE 1
RUN DATE: 06/17/2004 13:59 LOCK-IN ROSTER REPORT PERIOD: 07/01/2004 THRU: 07/31/2004

PROV ID	PROV NAME		MID	PERSON NAME		TYPE	START DATE	STOP DATE
1234567	LOCKIN	JOHN	MEDICAID					
			12345670000	WASHINGTON	GEORGE	LOK	06/01/2004	12/31/2382
			23456780000	LINCOLN	ABE	LOK	03/01/2004	12/31/2382
			34567890000	FRANKLIN	BEN	LOK	06/01/2004	12/31/2382
			CHIP-B					
			45678900000	ROOSEVELT	THOMAS	LOK	06/01/2004	12/31/2382
			56789010000	EDISON	THOMAS	LOK	03/01/2004	12/31/2382
			45678900000	EINSTEIN	ALBERT	LOK	03/01/2004	12/31/2382

B.3 Healthy Connections

B.3.1 Overview

As with Medicaid, the Department requires most CHIP-B participants to enroll and participate in the Healthy Connections Primary Care Case Management (PCCM) program. In counties where Healthy Connections operates as a mandatory program, participants who are non-responsive in selecting a Primary Care Provider (PCP) will be assigned to one. For additional information see Section 1.5 in the General Provider and Client Information section about the Healthy Connections program.

B.3.2 Referrals

The same services require a PCP referral under CHIP-B as with Medicaid and CHIP-A. See Appendix A, Healthy Connections for program information.

B.3.3 Remittance and Status Reports

The **remittance and status report** has up to 3 different payouts associated with Healthy Connections case management fees. These payouts will display in the **Financial Transactions** section of your weekly remittance and status reports. Each type of payout is identified by a different financial reason code.

- Financial reason code **126** is the HC payout for all participants enrolled in a traditional Medicaid program.
- Financial reason code **127** is the HC payout for all participants enrolled in a CHIP-A program.
- Financial reason code **129** is the HC payout for all participants enrolled in the CHIP-B program.

B.3.4 Participant Roster Report

In conjunction with the case management fee payment, a roster of enrollees is generated and mailed to PCPs. The roster lists all new, ongoing, and dis-enrolled Healthy Connections participants for the provider. The roster is separated into two categories, Medicaid and CHIP-B. Within each of these categories the report displays new enrollees, ongoing enrollees, and dis-enrollments.

The **Medicaid** category includes both traditional Medicaid and CHIP-A participants. The **CHIP-B** category includes only CHIP-B participants.

Note:
See the **Healthy Connections Appendix section A.6.2** for an example of the Healthy Connections roster.

B.4 Billing Instructions

B.4.1 Overview

The instructions for submitting claims for CHIP-B participants are the same as all traditional Medicaid or CHIP-A participants. See **Section 3** of this handbook for more detailed billing instructions. Additional rules apply when billing services for a CHIP-B participant. **All claims must be received within one year of the date of service.**

B.4.2 Billing for Program Coverage Splits

A claim which includes both CHIP-B and Medicaid services will be denied. For example, if the participant had CHIP-B coverage in July and then Medicaid coverage in August, the July CHIP-B services must be billed on one claim. The Medicaid services for August must be billed on a separate claim.

B.4.3 CHIP-B Billing Policies

The CHIP-B billing policies are the same as with any other traditional Medicaid or CHIP-A participant. For additional information see Section 2.1.1 in the General Billing Information section about Medicaid billing policies.

B.4.4 Claim Submission

See **Section** 2.2 for general claim submission information.

Electronic CHIP claims should be sent to EDS using HIPAA-compliant billing software. Send CHIP paper claims to:

EDS
P.O. Box 23
Boise, ID 83707-0023.

If you have questions about claims processing for CHIP participants, contact EDS at (800) 685-3757 or in the local Boise area at (208)383-4310.

B.5 Prior Authorization

B.5.1 Overview

The instructions for submitting requests for prior authorization for CHIP-B participants are the same as all traditional Medicaid or CHIP-A participants.

Carefully review the listing of covered and non-covered services for CHIP-B participants then refer to **Section 3** of this handbook for more detailed information on specific services that require prior authorization.

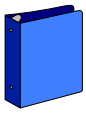
B.5.2 Previous Prior Authorizations

Previous prior authorizations are not a guarantee of payment if the participant's eligibility changes from Medicaid or CHIP-A to CHIP-B. Prior authorizations received under Medicaid will not be valid for CHIP-B if the service is not covered under CHIP-B.

> **Example:** a participant has a current prior authorization for non-medical transportation for the months of July and August. The participant has Medicaid coverage in July and CHIP-B in August. The non-medical transportation services rendered in July would be covered by the prior authorization, but the August services would not be covered because the participant was no longer eligible for the same level of benefits under the CHIP-B program.

See **Section 2.3** General Billing Information for additional information on obtaining a prior authorization for services.

For more information



see **Section 3** for questions concerning prior authorization for a particular services

B.6 Adjustments

B.6.1 Overview

When a claim is paid incorrectly, submit an adjustment request to EDS. Incorrect payments may result from changes to information received after initial payment.

Adjustments can be done only on paid claims or paid details. These are claims that are listed in the "Paid Claims" section of the remittance advice (RA). For more information on RAs, see Section 4.

Adjustments to paid claims must be made within two years after the calendar quarter in which the payment was received.

Medicaid, CHIP-A, and CHIP-B services are reimbursed from separate state and federal funding sources. Medicaid services are paid from one funding source, CHIP-A from a different funding source, and CHIP-B from a third funding source. Because CHIP services are not reimbursed from Medicaid funds, any claim adjustment that results in an overpayment to the provider must be refunded by either:

- Providing additional services that are paid from the same funding source, **or**
- Refunding the amount by sending a check from the provider to the State of Idaho, DHW Medicaid.

There are two types of transactions that may occur in the adjustment process: claim voids and claim adjustments.

Note:
Do **not** send a copy of the RA or a copy of the original claim with the adjustment.

B.6.2 Claim Voids

When a provider requests an adjustment to **void** a claim for a participant enrolled in a particular program (Medicaid, CHIP-A, or CHIP-B), the claim is voided and an accounts receivable transaction is set up. This transaction will remain outstanding in the system until claims have been paid for other services from the **same** program funding source or until a refund from the provider of services has been received and processed for the amount owed.

- **If claims have been paid from the same funding source as the voided claim:**
  On the same remittance and status report, the system will withhold the accounts receivable balance from the claims payment. If the claims payment amount for the funding source of the accounts receivable is less than the receivable balance, the entire payment for the funding source will be withheld and the receivable balance will be reduced by that amount. The transaction is shown in the ***Financial Transaction*** section of the weekly remittance and status report with the original setup amount less the amount refunded.
- **If no claims have been paid from the same funding source:**
  The transaction is displayed on the remittance and status report the week following the initial setup of the accounts receivable transaction in the ***Financial Transaction*** section. It is not shown again until new claims are processed and approved to pay from the same funding source.

- **When claims are approved to pay from the same funding source in subsequent financial cycles:** The transaction is shown in the *Financial Transaction* section of the new remittance and status report.

  Example: a provider requests an adjustment to void a claim for a CHIP-B participant because the services were rendered by a different provider. The claim is voided and an accounts receivable is set up. When claims are approved to pay from the CHIP-B funding source, the system withholds the overpayment amount from those claims until the total amount is recouped. The CHIP-B transaction and the paid amount from claims with the same funding source are shown in the ***Financial Transaction*** section of the weekly remittance and status report.

B.6.3 Claim Adjustments

When a provider requests an adjustment to **change** a claim for a participant enrolled in a particular program (Medicaid, CHIP-A, or CHIP-B) resulting in an overpayment to the provider, EDS makes the change, recycles it as a new claim, and sets up an accounts receivable for the transaction. Adjustments are shown as a net adjusted amount with a negative dollar amount and the balance owed against the original claim.

- **If claims are approved to pay with the same funding source:** Their payment is applied to the amount owed from the adjustment. It is shown on the ***Adjusted Claims*** section of the weekly remittance and status reports.

- **If no claims are approved to pay from the same funding source:** The financial transaction is displayed the week following the initial setup of the accounts receivable transaction on the ***Adjusted Claims*** section of the weekly remittance and status report. It is not shown again until new claims are processed and approved to pay from the same funding source.

- **When claims are approved to pay from the same funding source in subsequent financial cycles:** The remaining adjustment is shown in the ***Remaining Balance on Previous Adjustments*** section of the new remittance and status report.

  Example: a provider requests an adjustment to reduce the units of service for a participant enrolled in the CHIP-A program. An EDS financial clerk reduces the units of service on the claim and sets up an account receivable for the overpayment. When claims are approved to pay from the CHIP-A funding source, the system withholds the overpayment amount from those claims until the total amount is recouped. The CHIP-A transaction and the paid amount from claims with the same funding source are shown in the Adjusted Claims (first week) or the ***Remaining Balance on Previous Adjustments*** (future) section of the weekly remittance and status report.

B.6.4 Refunding Outstanding Overpayments

For both voids and adjustments, if no claims have been processed within 30 days of the initial accounts receivable setup, the provider is notified by letter of the outstanding accounts receivable. At that time, the provider is required to refund the overpayment by sending a copy of the letter and a check, made payable to **State of Idaho, DHW Medicaid**, to:

EDS
Attn: Financial Department
PO Box 23
Boise, ID 83707

For additional information regarding this process, call (800) 685-3757 or 383-4310 in the local Boise calling area. Ask for AGENT to speak with an EDS Provider Services Representative.